

Colorectal (Pelvic) Surgery

Introduction

Our clinical activities as general pelvic oncology launched at five years ago. Our main purpose of this trial was to challenge against conventional treating systems conventional treating systems those were usually divided into two divisions. Cooperation between urologist and general surgeons had been done more smoothly not in operative technique but in making oncological consensus concerning about pelvic malignancies.

The patients with intrapelvic malignancies (colorectal, urogenital) had been increased year by year, and the systems of main ward and training of co-medical stuffs for treating them also had been prepared gradually.

But we needed to work up the new strategy for pelvic surgery by only general surgeons between last January and May, because there were no full-time urologists in our division in same duration. Now we have an urologist, and will have one more staff soon.

Routine activities

1) Outpatient activities: The Outpatient clinic is open 5 days a week and more than 300 new patients were accepted last year. Other all outpatients who have undergone curative colorectal surgery are followed closely by their own doctors using various diagnostic modalities to detect early recurrence. Urologic outpatient clinic is also open on Wednesday.

2) Treatment system: Our pelvic oncology group consists of 5consultants (four general surgeons, and one urologist) and three to four residents, and carries out eighth to nine operations a week under general anesthesia. We have two conferences a week as for GI Malignancies; (1) image diagnosis conference with radiologists and endoscopists on Monday, (2) case conference on Wednesday or Thursday that we make therapeutic decisions on all new ceases with GI

malignancies through discussion with medical oncologists, endoscopists and surgeons. The surgical pathology conference is held monthly with attending surgeons and pathologists. Concerning the intrapelvic malignancies, we are also consulting with urologists (consultant and part-time) for each time.

3) Treatment modalities: In early cancer cases, many modalities have been introduced such as endoscopic resection or TEM (transanal endoscopic microsurgery). In addition, the laparoscopy assisted operation (Lap-Op) was introduced in 1994 and has since been used as a minimally invasive surgical technique. Patients with early cancer with submucosal invasion diagnosed histologically after endoscopic resection or those who have unresectable metastatic lesions were indicated for Lap-Op in our hospital till December 1997. Since January 1998 we have acquired the technique of wider lymphnodes dissection up to more than D2, so the indication of Lap-Op has been extending (see research activities).

4) ISR (internal sphincteric resection) is a new operative modality in Japan. We have already experienced 49 cases up to now since the first case was done 4 years ago. The candidates of this modality are the patients with rectal cancer suited less than 3cm from dentate line. The rate of Miles operation in the patients with lower rectal cancers ware extremely decreased in our hospital as a result. (from 35% to 4%).

Research Activities

1) Prospective none-randomized trial for the extension of the indication for Lap-Op has performed according to these criteria as follows 1. Within 5cm in diameter of tumor, 2. No mass over 7mm in diameter around the main tumor in CT image, 3. Excluding poorly differentiated adenocarcinoma. These criteria are established by operated cases only with preoperative information. At short-time outcome

of this prospective trial, disease free survival and survival at three years of Lap-Op was same as these of ordinary surgery in all stages. From January 2002, the indication for Lap-Op is extended to almost all patients with colonic cancer except patients with direct invasion to the other organs. About 60% of operable colon cancer was resected by Lap-Op in this year. Moreover we had been planning to extend the indication of Lap-Op to the patients with rectal cancer suited below the peritoneal reflection.

2) The extension of indication of natural anus preservation op. for extremely lower suited rectal cancer: this trial is started using intersphincteric resection (ISR) or local excision of tumor combined with preoperative or postoperative chemo-radiotherapy. This trial is on going accompanied informed consent of each patient. The purpose of this trial is to make and establish new other menu except rectal amputation for the patients with extremely lower suited rectal cancer.

3) Concerning the pelvic oncology: The dysfunction after surgery of patients with intrapelvic malignancies is an inevitable problem. But the objective evaluation

for damage of functions caused by intrapelvic autonomic nerve injury after operations is difficult. There are many methods for it, but stable data has not been available. To evaluate the efficacy of objective measurement for urinary or sexual functions, we started to accumulate objective and subjective data prospectively.

4) Nover urinary bladder sparing surgery for patients with advanced rectal carcinomas involving prostate or seminal vesicle: Total pelvic exenteration (TPE) had been believed to be the best surgical procedure for patients with rectal carcinomas invading prostate. As a results, patients required urinary and/or fecal diversion and QOL was decreased. To avoid TPE, we performed en bloc removal of rectum with prostate and seminal vesicle in selected patients using ISR or APR (abdominoperineal resection) with radical prostatectomy. This new approach has been done in five patients, and those patients's QOL was improved in urination and/or evacuation. We need move new strategy for obtaining better QOL.

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year	Total number	Colorectal cases			Stomach cases	Uro.cases
		colon	rectum	Total		
1999	412	93	90	183	92	60
2000	451	91	95	186	90	101
2001	423	103	93	196	57	111
2002	402	117	124	241	84	21
2003	417	129	111	240	69	29
SUM	2105	533	513	1,046	392	322

	1year	2year	3year	4year	5year
stage I	99	99	97	97	97
II	98	96	92	92	88
IIIa	95	91	91	91	83
IIIb	84	73	73	47	47
IV	64	38	38	25	15